

**Verification of Disability  
For Students with Attention Deficit Disorder**

Please have your Medical Doctor or your Clinical or Counseling Psychologist complete this form or use it as a basis for their narrative summary

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(Student's Name)

(Social Security Number)

is a patient of yours who attends or plans to attend Lakeland College. This student has indicated to the College that he or she has been diagnosed with Attention Deficit Disorder and plans to request accommodations to equalize his or her educational abilities at the post-secondary level.

Please complete this form or use it as the basis of a narrative summary and return it to:

Paul M. White  
Director, Academic Resource Center  
Lakeland College  
P.O. Box 359  
Sheboygan, WI 53082-0359

The Lakeland College Accommodations Review Committee will use the information you provide, along with other relevant information, in consideration of this student's request for educational accommodations. If you have any questions about the information requested or how the information will be used, please contact the Director of the Academic Resource Center at Lakeland College at 920-565-1412.

Thank you.

**Diagnostic Information**

1. DSM-IV diagnosis: \_\_\_\_\_
  
2. Level of severity: (Check One)     Mild     Moderate     Severe
  
3. Date of diagnosis: \_\_\_\_\_



3. Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? (Please describe your recommendations for services/accommodations in exam administration, or in-class accommodations.)

**Other Information**

In addition to the diagnostic report, please attach other information relevant to this student's academic adjustment.

**Certifying Authority**

Signature: \_\_\_\_\_

Print name and title: \_\_\_\_\_

License: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date: \_\_\_\_\_